STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 5, 6, 7, 8, & 9, 2015. Facility number: 001156 Provider number: 155505 AIM number: 100453350 Survey Team: Kewanna Gordon, RN-TC Megan Burgess, RN, Lora Brettnacher, RN (1/7, 1/8, 1/9, 2015) Tracina Moody, RN Census bed type: SNF: 20 SNF/NF: 58 Total: 78 Census payor type: Medicare: 11 Medicaid: 38 Private: 24 Other: 5 Total: 78 These deficiencies reflect state findings cited in accordance with 410 IAC	F000000	The following is the Plan of Correction for Robin Run Health Center regarding the Statement of Deficiencies dated 12/19/2013. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2-3.1. Quality review completed 01/12/2015 by Brenda Marshall, RN.			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure preferences for showers, wake up times, and bed times were assessed for 1 of 2 residents reviewed for choices. (Resident #124). Findings include: During an interview on 1/7/15 at 11:09 a.m., Resident #124 indicated the staff came and woke her up in the morning based on their schedule and had not asked her preferences when she was admitted. The resident indicated she did not choose how many times a week she took a shower, the time of the day, or the days of the week. She indicated the staff scheduled her shower days and time. She	F000242	It is the practice of the provider to assess preferences initially and periodically thereafter. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #124 has been interviewed regarding bathing and sleep-time preferences, and reasonable accommodations have been made. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Cognitively intact residents have been interviewed regarding bathing and sleep-time preferences, and reasonable accommodations have been made. **What measures will be put into place or what systemic**	02/01/2015

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	indicated if she asked for additional showers the staff indicated their schedule would not permit it. On 1/08/15 at 9:14 a.m., Resident #124's record was reviewed. The admission evaluation data form, dated 12/31/14 at 9:15 p.m., indicated the resident was alert and oriented to person, place, and time. The evaluation form indicated the resident was able to be understood and understood others. The resident's usual and customary preferences for bathing, bed time, and rise time were not completed on the evaluation form. The care plan, dated 1/2/15, did not reference the resident's preferences for bathing, wake up time, or bed time. The "Patient's Bath/Shower Record," provided by unit manager (UM) #3, on 1/9/15 at 11:30 a.m., indicated the resident was scheduled to have showers on Wednesdays and Saturdays during the evenings. The admission minimum data set (MDS) assessment had not yet been completed. During an interview on 1/08/15 at 3:43 p.m., the administrator indicated Resident #124's preferences for showers, bed times, and wake up times would most		**changes will be made to ensure that the deficient practice does not recur?** Residents will be interviewed as a part of the admission process, and per the comprehensive MDS schedule thereafter, about aspects of life in the facility that are significant to the individual and reasonable individualized accommodations will be made. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. **By what date will the systemic changes be completed?** February 1, 2015	

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	likely be documented in the social service notes and then incorporated into the care plans. During an interview on 1/09/15 at 11:59 a.m., UM #3 indicated a resident's preferences for shower times and wake up times were evaluated within 48 to 72 hours of admission. She indicated they usually asked their preferences during the initial assessment on admission and there was a place on the form for them to record the information. She indicated they only asked a resident's preference on the time of the day they preferred showers and not the days of the week because it was difficult with the number of residents to accommodate the day of the week as well. She indicated usually the residents only cared about the time of the day and not the day of the week. During an interview on 1/09/15 at 12:26 p.m., the administrator indicated the activities preference assessment was usually done within 7 days of admission and it addressed the resident's preferences for showers and wake up times. She indicated she would verify it had been completed for Resident #124. During an interview on 1/09/15 at 1:20 p.m., the administrator indicated the form entitled, "Resident interview for			

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	preferences for customary routine and activities for MDS," was completed on 1/9/15 after UM #3 and administrator had been made aware the resident had not been asked preferences on admission. On 1/09/15 at 2:29 p.m., the administrator provided the current policy entitled, "Quality of Life-Self Determination and Participation." The policy indicated a resident should be allowed to choose his/her activities, schedules, and health care in order to be consistent with his/her interests. The policy indicated the preferences should be assessed on initial assessment and periodically thereafter and should include sleeping and bathing schedules. 3.1-3(u)(1)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			

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	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a comprehensive care plan related to dialysis treatments. This deficient practice had the potential to affect 1 of 1 resident reviewed for dialysis care plan (Resident #123). Findings include: Resident #123 ' s record was reviewed on 1/8/15 at 9:45 a.m. The resident's diagnosis included, but was not limited to, Stage IV CKD (Chronic Kidney Disease) and the record indicated the resident received Hemodialysis three days a week. The treatment record, dated 1/1/15-1/31/15, indicated the AV fistula (site used for dialysis) was supposed to be checked daily and the thrill palpated 3 times per week. The record did not indicate the facility had developed a care plan for dialysis.	F000279	It is the practice of the provider to develop a comprehensive care plan related to dialysis treatment as applicable to the individual resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #123 has been discharged from the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** For all residents receiving dialysis, the comprehensive care plan addresses dialysis. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** For all resident receiving dialysis, the comprehensive care plan will address dialysis. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	02/01/2015

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	The "Daily Skilled Nurse's Note, " dated 1/7/15 at 8:30 a.m., indicated, "Received a call from transportation that Dialysis Center request return transfer to HC (Health Center) of resident. Writer call (sic) FNC (dialysis center) to inquire reason. Was told by [staff named] that he did not dialyze d/t (due to) not being able to access shunt ...." During an interview on 1/8/2015 at 10:42 a.m., the Director of Nursing Services (DNS) indicated Resident #123 went to the dialysis center on 1/7/15. She indicated the dialysis center did not return a communication form sent with the resident to the appointment. The DNS indicated the van driver who transported the resident informed the facility Resident #123 did not receive dialysis on 1/7/15 because the port was not able to be accessed. She indicated the facility sent a communication form to all appointments, but the dialysis center did not consistently return the form. The DNS indicated the facility did not have a book for recording dialysis information or for tracking receipt of the communication form. The DNS indicated nurses should palpate and auscultate the residents fistula (port for receiving dialysis) and record the residents blood pressure on the Medication Administration Record		A Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. **By what date will the systemic changes be completed?** February 1, 2015	

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	(MAR), upon the residents return from the dialysis center. During an interview on 1/9/15 at 10:15 a.m., the DNS indicated a care plan had not been developed for dialysis. 3.1-35(a)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a system for communicating care provided and health status during/following hemodialysis for 1 of 1 resident reviewed for dialysis care (Resident #123). Findings include: Resident #123's record was reviewed on 1/18/15 at 9:45 a.m. The resident's diagnosis included, but was not limited to, Stage IV CKD (Chronic Kidney Disease) and the record indicated the resident received Hemodialysis three	F000309	It is the practice of the provider to ensure that pertinent care provided, and health status during and following hemodialysis, is communicated. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #123 has been discharged from the community. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** The community will continue to send a written request for information pertaining to the care provided, and health status during and	02/01/2015

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	days a week. The treatment record, dated 1/1/15-1/31/15, indicated the AV fistula (access site used for receiving dialysis) was supposed to be checked daily and the thrill palpated 3 times per week. A "Daily Skilled Nurse's Note," dated 1/7/15 at 8:30 a.m., indicated, "Received a call from transportation that Dialysis Center request return transfer to HC (Health Center) of resident. Writer call (sic) FNC (dialysis center) to inquire reason. Was told by [staff named] that he did not dialyze d/t (due to) not being able to access shunt .... " During an interview on 1/8/2015 10:38 a.m., Unit Manager # 3, indicated the nurses usually sent a dialysis communication form to dialysis with Resident #123, however, the dialysis center did not always return those forms. During an interview on 1/8/2015 at 10:42 a.m., the Director of Nursing Services (DNS) indicated Resident #123 went to the dialysis center on 1/7/15. She indicated the dialysis center did not return a communication form sent with the resident to the appointment. The DNS indicated the van driver who transported the resident informed the		following hemodialysis, with each resident in transport to a scheduled hemodialysis treatment. In the event that the written information is not received upon return to the community, the community will reach out via phone to obtain this information. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The community will continue to send a written request for information pertaining to the care provided, and health status during and following hemodialysis, with each resident in transport to a scheduled hemodialysis treatment. In the event that the written information is not received upon return to the community, the community will reach out via phone to obtain this information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Quality Assurance Performance Improvement audit tool will be utilized daily times 4 weeks, then weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. **By what date will the systemic changes be completed?**	

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	facility Resident #123 did not receive dialysis on 1/7/15 because the port was not able to be accessed. She indicated the facility sent a communication form to all appointments, but the dialysis center did not consistently return the form. The DNS indicated the facility did not have a book for recording dialysis information or for tracking receipt of the communication form. The DNS indicated nurses should palpate and auscultate the residents fistula (port for receiving dialysis) and record the residents blood pressure on the Medication Administration Record (MAR), upon the resident's return from the dialysis center. During an interview on 1/8/15 at 2:30 p.m., LPN # 11 indicated she sent a Dialysis Communication Form to the dialysis center with the resident. She indicated she had not received a sheet back for Resident #123 on 1/7/15 when he returned from treatment. During an interview on 1/9/15 at 10:15 a.m., the DNS indicated there were no completed Dialysis Communication Forms in Resident #123's record and indicated a care plan for dialysis had not been developed. A policy entitled, "Dialysis Care,"		February 1, 2015	

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	received from the DNS at 11:00 a.m. on 1/8/15 indicated the facility was to, "Complete the Dialysis Communication Form and send to the dialysis center with the resident for each visit. This form should be completed by the dialysis center and returned with the resident." This document further indicated, "Upon return to the community from the dialysis center the resident will have their vital signs and access site checked for bleeding and recorded in the resident medical record...." 3.1-37(a)			
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure adequate hand sanitation during food distribution and while providing feeding assistance to 15 residents for 3 of 3 dining observations in 1 of 2 (Memory Care) dining rooms (Residents #19, #27, #34, #38, #39, #43, #48, #49, #54, #59, #61, #63, #72, #80, #90).	F000371	It is the practice of the provider to ensure adequate hand sanitation is maintained during food distribution and feeding assistance. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents #19, #27, #34, #38, #39, #43, #48, #49, #54, #61, #63, #72, #80, #90 have been monitored,	02/01/2015

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	Findings include: 1. On 1/5/14 at 1:17 p.m., during the lunch dining observation, Certified Nursing Assistant (CNA) #8 was observed to wipe Resident #49's mouth with a napkin with both hands before she offered Resident #34 a spoonful of food with her left hand. On 1/9/15 from 12:59 p.m. to 1:08 p.m., during the lunch dining observation, Memory Care Coordinator #7 placed both of his hands on Resident #43's shoulders before he retrieved and set up two dessert dishes for Resident #43 and Resident #48. He was then observed to place his right hand to his mouth and rubbed his lips as he retrieved and set up dessert for Resident #19. Next, he was observed to place his right hand on Resident #63's back as he used his left hand to wipe Resident #63's mouth with a napkin. He was then observed to use both hands as he wiped down Resident #63's table with the soiled napkin. Next, he removed Resident #63's soiled clothing protector with both of his hands before he patted Resident #19's back with his left hand and wiped his nose with his right hand. He was then observed to pat Resident #63 on his back with his right hand and wiped food crumbs off the resident's lap with his left hand. He then adjusted		and are not currently exhibiting any signs or symptoms of active infection. Resident #59 has been discharged from the community. CNA #8, CNA #9, and Memory Care Coordinator #7 have been educated on proper technique for food distribution and feeding assistance. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** CNA #8, CNA #9, and Memory Care Coordinator have been educated on proper technique for food distribution and feeding assistance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Healthcare Center associates will be educated on proper technique for food distribution and feeding assistance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Quality Assurance Performance Improvement audit tool will be utilized 3 times weekly times 4 weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance	

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	Resident #63's foot rest with both hands before he began to wipe down Resident #72's lap with both hands. Next, he retrieved and set up two dessert dishes for Resident #38 and Resident #90 with both of his hands. The Memory Care Coordinator #7 was not observed to perform hand sanitation in between feeding assistance and resident care. During an observation on 1/9/15 at 1:13 p.m., CNA #9 used her right hand to wipe Resident #34's mouth with her soiled clothing protector before she offered Resident #49 a spoonful of food with her right hand. CNA #9 was not observed to perform hand sanitation in between feeding assistance provided for Resident #49 and Resident #34. During observations on 1/9/14 from 8:55 a.m. to 9:07 a.m., the Memory Care Coordinator (MCC) was observed assisting residents during the breakfast meal. The MCC was not observed to sanitize his hand between resident to resident contact or utilize gloves during the following observations: The MCC touched Resident #59's arm with his hand then picked up Resident #54's fork with his right hand and put it into Resident #54's hand. The MCC picked up Resident #27's fork and put it into her hand and used his hand to guide		Improvement committee. **By what date will the systemic changes be completed?** February 1, 2015	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the fork to her mouth. The MCC touched Resident #61's wheelchair, patted her on the arm, touched the right side of his face, and collected soiled clothing protectors from the tables. The MCC picked up Resident #80's fork and cut her burrito in half. The MCC touched Resident #27's arm, touched the left side of his face and then proceeded to touch Resident #39's hand. During an interview on 1/9/15 at 1:19 p.m., Licensed Practical Nurse (LPN) #10 indicated staff should have washed their hands after they became soiled, or after a resident was touched, before feeding assistance or resident care was provided to a different resident. A policy titled "handwashing/Hand Hygiene" identified as current by the Administrator on 1/9/14 at 2:30 p.m., indicated, "...The facility considers hand hygiene the primary means to prevent the spread of infections... All personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)... Before and after handling food... Before and after assisting a resident with meals... After handling			

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	155505	A. BUILDING 00 B. WING	01/09/2015

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	soiled or used linens... After handling soiled equipment or utensils...." 3.1-21(i)(2) 3.1-21(i)(3)			
F000464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to ensure sufficient space to permit unobstructed passage of residents' wheelchairs and walkers during dining in the main dining room for 2 of 2 dining observations. (Residents #25, #160, #56, #119, #29, #70, #106, #51, #28, #124, and #1). Findings include: On 1/5/15 at 12:35 p.m., Resident # 25 was observed sitting in a wheelchair at a table and an unidentified resident was sitting in a dining chair directly behind Resident #25. LPN #1 moved Resident #25 away from the table in order for certified nursing assistant (CNA) #2 to move Resident #160 between Resident	F000464	It is the practice of the provider to ensure sufficient space to permit unobstructed passage of resident wheelchairs and walkers during dining. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The IDT has reviewed and revised the table positioning in the Dining Room to ensure unobstructed pathways for all resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** The IDT has reviewed and revised the table positioning in the Dining Room to ensure unobstructed pathways for all resident. **What measures will be put into place or what systemic changes will be made to**	02/01/2015

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	#25 and the unidentified resident. On 1/05/15 at 12:42 p.m., Resident # 56 was observed to lift her walker up over the unidentified resident sitting in a dining room chair and Resident #25's wheelchair because Resident #56's walker would not fit between the wheelchair and dining room chair. On 1/05/15 at 1:07 p.m., unit manager (UM) #3 moved Resident # 119 to allow 3 unidentified residents leaving the dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her. On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at a table and Resident #70 was observed sitting in his wheelchair directly behind her. The director of nursing (DON) moved Resident #29's wheelchair closer to the table. Then the DON moved Resident #70 away from the table in order for UM #3 to move Resident #106's wheelchair through to his table. On 1/09/15 at 1:06 p.m., Resident #56 was observed to be unable to fit her walker between Resident # 51's wheelchair and Resident #28's wheelchair. The administrator and		**ensure that the deficient practice does not recur?** The IDT has reviewed and revised the table positioning in the Dining Room to ensure unobstructed pathways for all resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Quality Assurance Performance Improvement audit tool will be utilized 3 times weekly times 4 weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. **By what date will the systemic changes be completed?** February 1, 2015	

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	activities director were observed assisting Resident #56 by stabilizing her from behind while UM #3 lifted the walker over the residents' wheelchair wheels. On 1/09/15 at 1:11 p.m., Resident #124 was observed to be unable to pass between Resident #70's wheelchair and Resident #29's wheelchair when exiting the dining room. The administrator was observed moving Resident #70's wheelchair up closer to table and guided Resident #124's wheelchair by grabbing the leg bar and pulled her through the gap between Resident #70's wheelchair and Resident #29's wheelchair. On 1/09/15 at 1:16 p.m., Resident #1 was observed to be unable to pass between Resident #70's wheelchair and Resident #29's wheelchair. UM #3 moved Resident #70 away from table so Resident #1 was able to fit through and exit the dining room. During an interview on 1/09/15 at 1:21 p.m., UM #3 indicated there was a problem getting residents to and from tables when the tables had been recently moved and not placed back into the proper position. She also indicated it was a problem depending on where the residents sat.			

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	During an interview on 1/09/15 at 1:28 p.m., CNA #4 indicated it was not unusual for the staff to move the residents up closer to the table or temporarily out of the way to allow other residents to pass by them. She indicated the residents sat in different locations for different meals and depending on which residents were seated near each other it happened more often. During an interview on 1/09/15 at 1:54 p.m., the administrator indicated she was aware they needed to occasionally assist residents to and from their tables past other residents. She indicated there was no policy regarding dining room spacing or accommodations. 3.1-19(w)(4)(B)(ii)			
F009999	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (5) Needs of specialized populations served. This state rule was not met as evidenced	F009999	It is the practice of the provider to ensure that all Healthcare Center associates receive required dementia training. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Therapist (PT) #1 and #2 have completed 3 hours of dementia training. **How other residents having the potential**	02/01/2015

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	by: Based on employee record review and interview the facility failed to ensure 2 of 2 therapy employees had completed dementia training. Findings include: Employee records were reviewed on 1/9/14 at 11:00 a.m. The record indicated Physical Therapist (PT) #1 was hired on 4/10/07 and PT #2 was hired on 5/12/08. The record lacked evidence PT #1 or PT #2 had completed the required inservice training for care of residents with dementia. During an interview on 1/9/14 at 11:45 p.m., the Administrator stated, "It is not "corporation named" practice for therapist to have dementia training." She indicated the therapy department took care of residents with dementia daily. During an interview on 1/9/14 at 12:16 p.m., the Administrator indicated she was unable to find a policy regarding dementia training requirements for employees.		**to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Therapist (PT) #1 and #2 have completed 3 hours of dementia training. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All associates in the Therapy department will complete 3 hours of dementia training now, and have been placed on the schedule for this training on an annual basis. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator will review the schedule for dementia training each month, cross-reference this with the actual attendance, in order to ensure that all Healthcare Center associates remain in compliance with the required annual dementia training throughout the year. **By what date will the systemic changes be completed?** February 1, 2015	